Medicaid Financial Assistance Programs Annual Report

State Fiscal Year 2022

Report Prepared in Response to Senate Bill No. 259 (Act 542) of the 2022 Regular Session

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Executive Summary

Senate Bill (SB) 259 of the 2022 Regular Legislative Session, known as the "Public Benefit Integrity Law" requires annual reports from state agencies administering federal and state social services and financial assistance programs on the policies and procedures in place to enhance program integrity; to eliminate fraud, waste, and abuse of federal and state resources.

- In response to the Public Benefit Integrity Law, the Louisiana Department of Health (LDH or the Department) will submit an annual report fulfilling this requirement for benefit eligibility, if applicable.
- The frequency with which the agency performs the verification. (Information needed for both provider and recipient integrity activities).
- A description of any barriers the agency identifies to implementing additional program integrity measures, including privacy or data sharing impediments, administrative burden, and any increase in financial cost.
- A description of all metrics and data points used by the agency to measure the success of the program, including all metrics and data points related to program integrity and fraud.
- For the preceding calendar year, measures of access in the program, including:
- For each month, the number of applications received, the percentage of applications denied, and the percentage of applications denied for procedural reasons.
- Monthly call center performance metrics for call centers serving clients and applicants, including the average number of calls and the average and maximum call wait times.
- The average caseload per caseworker.
- A detailed description of the program's administrative appeals process for clients, including but not limited to the number of hearings requested by clients and the number of hearings waived by clients.

As with previous studies, the Department has always valued the role of public benefits in our service delivery system and has continued to work in tandem to identify viable solutions to not only address the concerns regarding quality service and support but many others as well.

This report consist of data from Louisiana Medicaid and the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).

Medicaid Reporting

1.1 Budget Allocated for Program Integrity, Fraud, Waste, & Abuse

Preventing and detecting Medicaid fraud, waste, and abuse requires a collaborative effort by various parties. LDH created the Program Integrity (PI) section within Medicaid to ensure programmatic and fiscal integrity of the Louisiana Medicaid program in order to meet federal mandates required to obtain the federal share of the budget that supports the program.

For fiscal year (FY) 2022-2023, the total dollar amount of the agency's budget allocated for the PI section was $4,800,087. This figure total does not include the cost of the Gainwell Surveillance and Utilization Review System (SURS) staff. Costs for SURS are included in the Gainwell fiscal intermediary contract, which is not itemized, to determine the costs of individual tasks.

1.2 Policies & Practices for Reduction of Fraud, Waste, & Abuse

Eligibility Determinations

Medicaid policies and practices regarding the eligibility process are in place to ensure accurate eligibility determinations. PI's oversight of provider and beneficiary fraud, waste, and abuse policy can be found in Appendix A.6. According to federal regulations, eligibility factors must be verified by data sources available to the agency for accuracy outlined in Appendix A.2. While some eligibility factors call only for self-attestation, if the agency has information that questions the self-attestation, verification can be required to resolve inconsistencies or differences. The agency must have documentation in the case record to support the result of all eligibility determinations.

The agency also employs a "prudent person" concept for eligibility staff. They must be prudent when the circumstances of a particular case indicate the need for further inquiry. Additional verification or substantiation should be obtained whenever the information provided by the applicant or enrollee is incomplete, unclear, or contradictory. In determining whether an eligibility worker has used the "prudent person" concept, the reasonableness of an action or decision must be viewed based on his or her knowledge of, and experience with, the Medicaid program.

The eligibility manual provides staff with an explanation of fraud, waste, and abuse. It gives descriptions of the possible recipient and provider fraud and abuse, steps in handling complaints on fraud and abuse, as well as guidance on making appropriate referrals to staff.

Electronic Medicaid Eligibility Verification (eMEVS)

The eMEVS is an electronic system used to verify recipient Medicaid eligibility. This electronic verification process will provide date-specific eligibility which will help reduce claim denials related to eligibility. It can help to eliminate Medicaid fraud. The eMEVS is available 24 hours a day, seven days a week, except for a short maintenance window each week. The eMEVS provides Medicaid providers with easy and immediate access to current Medicaid recipient eligibility information. This system is used to assist providers to verify recipient Medicaid eligibility.

The Encounter Unit Desk Procedure, refer to Appendix A. 4, states that the eMEVS system is used to verify Medicaid recipient eligibility and can help eliminate Medicaid fraud.

The following Error Codes are in place for cost avoidance to help eliminate fraud, waste, and abuse:

- 932 – Bill Third Party – Please bill third party carrier first (TPL Cost Avoidance)
- 275 – Recipient is Medicare Eligible (Medicare Cost Avoidance)
- 492 – HMO EOB requires review (LaHIPP Cost Avoidance)

Provider Audits

The Medical Assistance Program Integrity Law (MAPIL)[1] passed during the 1997 Regular Legislative Session. The intent of the law was to combat and prevent fraud and abuse committed by some health care providers participating in the medical assistance programs, and to negate the adverse effects such activities have on fiscal and programmatic integrity.

The enactment of MAPIL required an update to Medicaid rules, in which the SURS rule[2] was published to allow the department to enforce the requirements of MAPIL. Medicaid PI section audits and penalizes providers based on the requirements of the MAPIL law and SURS rule.

1.3 Individuals consisting of providers and beneficiaries who improperly received benefits & dollar amount of benefits calendar 2022.

The agency can confirm that there were 7,717 providers who received an improper payment identified by MCOs (Managed Care Organization) due to waste and error. MCOs identified 979 providers who received an improper payments due to fraud and abuse. PI identified 395 providers who received an improper payment due to fraud, waste, and abuse and 606 beneficiaries identified to have received benefits improperly. This total comes to 9,697 providers and beneficiaries combined to have received payments and benefits improperly.

1.3.1 Type & Amount of Improper Payments Calendar 2022

Total Improper payments identified is MCOs $21,727,405 and PI $4,235,533.

1.3.2 Type & Amount of Provider Improper Payments Prevented Calendar 2022

MCO Prepay edits $7,422,779, LDH Prepay edits $1,428,996, and Electronic Visit Verification (EVV) Blocked improper payments $22,151,913 = $31,003,688.

1.3.3 Dollar Amount Saved by Preventing/Recouping Improper Payments Calendar 2022

Type	YTD 2022
Total Provider Improper Payments Recouped: (MCO) Managed Care Organization & Program Integrity.	$ 18,513,731
Program Integrity Program Integrity-Provider Audit recoupment $4,103,059 + Delinquent balance recoupment $353,633 + Federal Share reclamation $2,344,976.	$ 6,801,668
MCO	$ 11,712,063

[1] La. R.S. 42:437.1, et seq

[2] Louisiana Register Vol. 29, No.04, 04/20/2003

1.4 Policies & Procedures to Determine Eligibility

The agency has numerous policies, processes, and procedures to determine eligibility, which include but are not limited to:

- A Medicaid Eligibility Manual (MEM) containing a description of groups covered and eligibility criteria for each group. It provides a list and explanation of financial and non-financial eligibility factors and provides steps for determining financial eligibility. It also includes chapters concerning the processing of applications, renewals, and changes along with other general operating policies such as third-party liability, fair hearings, verification and documentation, fraud and recovery, and charts containing income and resource levels and other information used in the eligibility determination process. This is a public-facing document and a link can be found on the LDH website.
- Internal procedures manual including Standard Operating Procedures, Temporary Operating Procedures, and other resources to be used in determining eligibility.
- An email account - Medicaid.EligibilityPolicyUnit@LA.GOV - for the Eligibility Program Operations (EPO) State Office section where Medicaid Analysts and Supervisors can submit questions concerning eligibility policy and/or procedures for clarification or direction before completing an eligibility determination.
- An online technical support application that allows Medicaid Analysts and Supervisors to submit help tickets concerning functionality or issues with the eligibility determination system, LaMEDS. Medicaid Technology Systems staff manage this help desk.
- Design documents, user and operational guides, business rules, and other technical documents associated with Medicaid eligibility and enrollment system, LaMEDS. LaMEDS can receive information from applicants/members and other electronic data sources and complete eligibility determinations without the involvement of eligibility staff.

In determining eligibility, with respect to verifying eligibility factors, the agency:

- Allows for self-attestation only of some factors,
- Allows for self-attestation with comparison and/or verification from databases or data exchanges,
- Requires written/hard copy proof of the factor, or
- Uses information received directly from databases or data exchanges.

The following databases or data exchanges are used in the eligibility determination process with the indicated frequency and purpose:

- Verify Annual Household Income and Family Size (IFSV) Service – Provides the most recent tax return information from the Internal Revenue Service (IRS) to verify household income for a tax filer. The service is invoked automatically in a batch process for new applications, renewal of benefits, reopening of benefits, and case changes that are treated as new applications such as adding a new person to a case or an existing case member now requesting benefits.

- Address Correction Service - An interface between Production Support Services (mailroom) and the United States Postal Service (USPS). Addresses on outgoing mail from LaMEDS are checked daily against the USPS for reported changes/forwarding addresses. LaMEDS will update the address on file with one returned by USPS.
- Social Security Administration Composite – Provides information on Social Security Number (SSN), citizenship, indication of death, date of birth, and Social Security Title II income. SSN, citizenship, death and birth are accessed automatically in real-time for any new individual added to LaMEDS. Title II income can be invoked on demand by LaMEDS users.
- TALX – Provides employment wage information and is accessed automatically in real-time at application and renewal. Can also be invoked on demand by LaMEDS users.
- Verified Lawful Presence – Provides immigration status information and is accessed automatically in real-time at application, renewal, or any time the verification source is a client statement when eligibility is determined. Can also be invoked on demand by LaMEDS users.
- Louisiana Workforce Commission (LWC) – Provides state employer wage data and unemployment income automatically in real-time at application, renewal, and reported changes or adding of employment or wage amount. Can also be invoked on demand by LaMEDS users.
- LWC Quarterly Wage Update – LWC Wage data is updated quarterly and LaMEDS receives this information quarterly for all Medicaid members with an LWC record for comparison to wage data currently on file.
- State Online Query - Internet (SOLQ-I) – Provides information from Social Security Administration (SSA) that verifies SSN, citizenship, name, date of birth, date of death, disability, Medicare coverage, Social Security Title II income, and Supplemental Security Income (SSI) Title XVI data. Accessed automatically in real-time at application, renewal, and case change. Can also be invoked on demand by LaMEDS users.
- Beneficiary Earnings and Data Exchange (BENDEX) - Provides information from SSA regarding Social Security claim numbers, Social Security Title II income including annual Cost of Living Adjustments, and Medicare coverage premium amounts. Data exchange is done monthly with an additional transaction done annually for Cost of Living Adjustment information.
- Medicare Buy-in – Provide information from the Centers for Medicare and Medicaid Services (CMS) on Medicare enrollment and in some instances state residency. Information is received monthly.
- Date of Death – Daily interface that provides the date of death information from the Louisiana Vital Records Registry.
- Department of Corrections (DOC) – Daily interface with the Louisiana Department of Corrections that provides incarceration status and pre-release information.
- State Data Exchange (SDX) – Daily interface with the SSA which provides for Medicaid eligibility of SSI recipients.
- Louisiana Department of Revenue – Bi-annual interface which provides Louisiana tax return information on tax filing status, yearly income, and household size.
- Territory Beneficiary Query (TBQ) – Daily interface with CMS which provides information on Medicare claim number, Medicare code, Medicare start and end dates, Medicare indicator, and Medicare source code.
- Third-Party Liability (TPL) – Daily interface with the internal Medicaid Management Information System (MMIS) that provides private health care coverage data received through a contract with Health Management Systems, Incorporated (HMS).

- Louisiana Automated Management Information (LAMI) Income Verification – Provides earned income records from the Louisiana Department of Children and Family Services SNAP and TANF benefit records. Data is accessed automatically in real-time at application, renewal, and case change. This data can also be invoked on-demand by LaMEDS users.
- Public Assistance Reporting Information System (PARIS) – Quarterly data exchange that provides information on members identified to be receiving public assistance in one or more states, Veterans Administration compensation and pension payments, and active or retired civilian and military employees potentially receiving income.

1.5 Policies & Procedures to Determine & Identify Ineligibility

Per federal regulations, the agency must promptly re-determine eligibility when it receives information about a change in a member's circumstances that may affect eligibility. Per agency policy, members are required to report changes in their circumstances within 10 days of occurrence. Members are informed of all decision notices and requests for information notices of the reporting of changes requirement. These changes can be reported electronically through an online Self-Service Portal, by mail, by telephone, in person at a local office, by fax, or by email. The agency also receives information on changes in circumstances through interfaces and data exchanges with other entities that provide pertinent data on eligibility factors. Furthermore, the agency is required to review and renew eligibility at least once every year to determine if members still meet eligibility guidelines for coverage. Members are given 30 days to return renewal information.

The agency's eligibility manual, procedures manual, and system business rules and operating guidelines provide how reported information should be handled and timeframes for associated tasks assigned to eligibility staff. Some changes can be handled immediately and automatically by the system while others may take longer as it could require staff review or requesting additional information or verification before being processed. A re-determination of eligibility will then be made. If found ineligible or there is a reduction of benefits, the member will be sent an advance notice at least 10 days before the date of action per federal regulations. This means the member could be terminated as early as the end of the current month that the notice is sent, or the end of the following month depending on the day of the month the notice is sent.

1.6 Policies & Procedures to Identify Work Search Requirements for Eligibility

There is no program-wide federal, state work, or work search requirement for the Medicaid program. However, one optional group the agency elected to cover has a work requirement as an eligibility factor. The Ticket to Work and Work Incentives Improvement Act – Basic Coverage Group described in Louisiana as the Medicaid Purchase Plan does require individuals to be working and paying all applicable taxes.

1.7 Frequency of Verification Activities

At a minimum, the agency verifies the individual is still working annually through its renewal process. The agency may verify more frequently based on reported changes by the individual.

1.8 Barriers to Implementation of Program Integrity Measures

One barrier to program integrity is the low pay and turnover in eligibility staff. Essentially the agency has a continual cycle of less experienced staff that are more susceptible to incorrect application of policy and procedures and errors in eligibility determinations.

Act 586 of the 2014 Regular Session prevents CMS (Centers of Medicare and Medicaid Services) audits to be performed by a RAC (Recovery Audit Contractor) from auditing any MCO encounters for fraud, waste, and abuse.

1.9 Metrics & Data Points Measuring Success of Program Integrity & Fraud

As described in the agency's Strategic Plan, performance indicators are reported in the Louisiana Performance Accountability System (LaPAS). The chart below lists PI section key metrics measuring the success of the program.

KPI	Unit	Description
Days to close audit	Surveillance Utilization Review System (SURS)-PI	Average number of calendar days an audit is open until closed
AVG Identified per audit	SURS-PI	Average amount of a provider audit overpayment identified
Referral Acceptance Rate	SURS-PI	Number of provider's fraud referrals referred to the MFCU(AG) and accepted by MFCU (AG)
% provider audits with overpayment	SURS-PI	Number of audits with dollars identified over total cases closed
Total provider overpayment Identified	ALL-PI & MCO	Total amount of provider overpayments identified
Total provider monetary penalties accessed and recouped	SURS-PI	Total amount of provider monetary penalties accessed and recouped
Total MFCU provider fraud Referrals	SURS-PI	Total number of provider fraud referrals submitted to MFCU (AG)
Data Mining Percentage Opened	SURS-PI	Total percentage of provider audits opened as a result of data mining to total audits opened over the same period.
Complaint Percentage Opened	SURS-PI	Total percentage of provider audits opened as a result of a tip/complaint to the total number of audits opened over the same period.
Number of provider complaint audits opened	SURS-PI	Total number of provider audits opened as a result of a tip/ complaint
Number of provider data mining audits opened	SURS-PI	Total number of provider audits opened as a result of data mining
% provider data mining audits closed	SURS-PI	Total percentage of provider audits closed as a result of data mining to total provider audits closed by year
% provider complaint audits closed	SURS-PI	Total percentage of provider audits closed as a result of a tip/complaint to total provider audits closed in the same period.
Total overpayment recouped	ALL-PI & MCO	Total amount of provider overpayments recouped as a result of provider audit

Total amount of provider overpayments prevented	ALL-PI & MCO	Total amount of prepays conducted, adjudication edits stopping and services being blocked from payment
Number of beneficiary fraud complaints received	Medicaid Beneficiary Fraud Unit (MBFU)-PI	Total number of beneficiary fraud complaints received
LaPAS: Number of fraud complaints reviewed/completed	MBFU-PI	Total number of beneficiary fraud complaints reviewed and complete
Number of LA Lotto reviews (Beneficiary)	MBFU-PI	Total number of lottery reviews completed
Number of beneficiary data mining reviews	MBFU-PI	Total number of reviews completed as a result of data mining
LaPAS: Number of law enforcement referrals (Beneficiary)	MBFU-PI	Total number of beneficiary law enforcement referrals
Number of beneficiaries terminated	MBFU-PI	Total number of beneficiaries terminated from Medicaid as a result of a complaint or data mining completed review
LaPAS: Annual number of provider exclusion	Provider Compliance-PI	Total number of Medicaid exclusions and terminations issued
LaPAS: Number of audits/reviews	ALL-PI & MCO	Total number of audits and reviews closed by MCO-SIU and PI
LaPAS: Amount of overpayments identified post and pre-pay	ALL-PI & MCO	Total amount of identified from post and pre-pay audits and reviews
LaPAS: Number of notices and referrals sent to the Attorney General	ALL-PI & MCO	Total number of fraud referrals and notices sent to the Attorney General (MFCU)

1.10 Application Metrics Based on Procedural Reasons

1.10.1 Monthly Call Center Performance Metrics

The agency is required to report to CMS for call center metrics. Refer to Appendix A. 1.

1.10.2 Average Caseload per Caseworker

In SFY22, the agency reports approximately 2,204 caseloads per caseworker active cases as of June 30, 2022. Data provided by Deloitte.

1.11 Administrative Appeals Process

Every applicant for, and enrollee of, Louisiana Medicaid benefits has the right to appeal any agency action or decision and has the right to a fair hearing in the presence of an impartial hearing officer. The information on how to appeal a decision is provided on every eligibility decision notice sent. Appeal requests received directly by the agency or through the Division of Administrative Law (DAL) first goes the agency's Centralized Appeals Unit (CAU).

The (CAU) is responsible for fair hearing requests resulting from a Medicaid Eligibility denial or proposed closure and will complete all necessary appeals activity resulting from the request. First, CAU will review whether the eligibility decision was correct according to policy and procedures. If it is believed that the decision was incorrect, the CAU will work with eligibility staff to review and correct it if necessary. A correction would result in an agency reversal of the decision and a new eligibility decision notice to be sent. If the original decision was correct, the CAU would be responsible for the preparation of the summary of evidence documents and submittal to the DAL. CAU represents the agency and is responsible for the presentation of the summary of evidence documents at the fair hearing.

The DAL is responsible for scheduling fair hearings and provides an impartial hearing officer who assures the Medicaid agency has correctly applied federal and/or state law (basis of the Medicaid policy) in the specific case in appeal. The hearing officer will take the information presented in the fair hearing by the agency and the appellant and render a decision. In general, a decision rendered by DAL should not be considered a revision to the state Medicaid policy. The agency will take necessary action based on the outcome of the fair hearing. The agency or the appellant can appeal the DAL's decision to the district court.

The chart below indicates the number of requests for hearings received in 2021 and the outcome of the cases.

Note: Not all fair hearing requests for 2021 had an outcome or decision in 2021.

Month	Hearings Requested	Hearings Waived by Client (Withdrew Fair Hearing or Failed to attend hearing)	Agency Decision Upheld (Affirmed)	Ruled in favor of Appellant	Dismissed Due to Agency Reversals
January	194	68	16	0	68
February	210	76	18	1	78
March	326	117	45	0	120
April	235	86	19	1	83
May	161	50	8	0	67
June	254	40	22	3	89
July	477	135	35	1	241
August	368	64	19	0	228
September	207	26	10	0	91
October	189	22	18	0	79
November	167	57	11	0	63
December	227	100	28	2	63

The chart below indicates the number of provider requests for hearings received in calendar year 2022 administered by PI. Providers can appeal improper payments and exclusions/terminations.

Provider Appeals Administered Calendar 2022	Totals
Provider audit/overpayment or improper payment appeals administered	8
Provider Compliance Exclusion/Termination appeals administered	18

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Reporting

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental foods, nutrition education, breastfeeding promotion and support, and referrals to health care and social services to low-income pregnant, postpartum and breastfeeding women, infants, and children up to age five. In Louisiana, the WIC Program is administered through the LDH Office of Public Health (OPH), and Bureau of Nutrition Services. Louisiana WIC is 100% federally funded by the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS).

2.1 Budget Allocated for Program Integrity, Fraud, Waste, & Abuse

This data does not exist for the Louisiana WIC Program. The USDA, the federal funding agency for WIC, and the Code of Federal Regulations (CFR) do not require reporting of this dollar amount or percentage.

2.2 Policies & Practices for Reduction of Fraud, Waste, & Abuse

Program integrity to reduce fraud, waste, and abuse of WIC Program benefits is incorporated throughout the CFR that governs the WIC Program and in Louisiana WIC Policies and Procedures for a clinic, participant, and vendor management operations, including participant eligibility and enrollment, cost containment, benefit issuance and redemption, fraud and investigations, and participant and vendor violations. The federal regulations that govern the WIC Program (7 CFR Part 246) can be found here. To maintain program integrity and reduce fraud, waste, and abuse of program benefits, applicable Louisiana WIC Policies and Procedures are included with the submission of this report and describe:

- Rights and Responsibilities for Controlling Violations: Informing WIC clinic staff of their rights and responsibilities, informing applicants/participants of their rights and responsibilities, preventing and monitoring for dual participation, investigating, sanctioning, and issuing claims against applicants/participants for program violations, investigating and enforcing disciplinary action against WIC clinic staff for program violations. Details are outlined in Appendix A.11.
- Electronic Benefit Transfer (EBT) Card Stock and Inventory: Monitoring for the fraudulent disposal of WIC food benefits and LA WIC EBT cards. Details are outlined in EBT Card Stock and Inventory Appendix A.12.
- High-Risk Vendors: Per Federal Regulations, WIC identifies high-risk authorized WIC vendors (grocery stores) at least once a year using high-risk criteria approved by the USDA. High-risk vendors are those identified as having a high probability of committing a vendor violation through the application of Louisiana WIC's established high-risk indicators. Per federal regulations, WIC conducts compliance investigations (in the form of Compliance Buys or Inventory Audits) on a minimum of 5% of vendors annually. Details are outlined in WIC Vendor Policies Appendix A.15, A.16, A.17, and A.18.
- Cost Containment: WIC establishes and applies limits on the amount of reimbursement allowed for WIC Approved Food Items based on a vendor's peer group and price competitiveness. The Maximum Allowable Reimbursement Level (MARL) is the reimbursement amount above which Louisiana WIC will make price adjustments on WIC Transactions to ensure WIC approved food items are not paid above a reasonable level. These procedures allow the program to control food costs, ensure integrity, and safeguard against misuse of program funds, dictating a maximum allowable dollar amount that an authorized vendor may claim for each food item sold to a WIC participant. Details are outlined in Appendix A.13, A. 14, and A.19.

- Bank Payments/EBT Processing: Louisiana WIC generates a monthly WIC EBT Distribution Report, which details a monthly breakdown of EBT claim reimbursements by WIC vendors. It is used to validate the WIC EBT Processor's (Solutran) Monthly Bank Statement, which details the daily EBT claim reimbursements made to Vendors for one process month.

2.3 Beneficiaries Who Improperly Received Benefits & Dollar Amount of Benefits

The WIC Program does not issue cash assistance benefits or make payments to individuals; therefore, data specific to the type and amount of improper payments, type and amount of improper payments prevented, and the dollar amount the state saved in preventing or recouping improper payments does not exist for WIC.

2.4 Policies & Procedures to Determine Eligibility

WIC applicants must meet all of the following eligibility requirements: categorical, residential, income, and nutrition risk. WIC staff must obtain proof of Louisiana residency from each applicant/participant at the time of application, certification, recertification, and transfer from outside of Louisiana. WIC staff must also obtain proof of identity from each applicant/participant at certification/recertification and the caregiver/proxy when issuing WIC food benefits. WIC staff must determine income eligibility for each applicant/participant. An individual is adjunctively income eligible to participate in the WIC Program if documentation shows that the individual is currently enrolled in the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), Louisiana Medicaid (including LaCHIP and LaMOMS only), or Temporary Aid to Needy Families (TANF). Adjunctively eligible individuals must provide proof of current participation in at least one of the above programs by providing:

- Proof of current Louisiana Medicaid enrollment (via WIC staff online eMEVS verification) or current Medicaid enrollment letter. The physical Medicaid card is not required for proof of adjunctive eligibility. Electronic verification (such as smartphone online lookup) is acceptable when the WIC applicant's information is listed. The enrollee's name and current eligibility period must be visible.
- TANF letter or card showing current eligibility dates.
- SNAP Notification of Eligibility letter specifying the WIC applicant's name and current certification dates. Electronic verification (such as smartphone lookup) is acceptable when the WIC applicant's information is listed. SNAP grocery receipts and the Louisiana Purchase card itself are not acceptable proof of current adjunctive eligibility for WIC Program enrollment.

WIC staff must obtain documented proof of gross household income to assess income eligibility of non-adjunctively eligible applicants for participation in the WIC Program. At each application, certification, or recertification, WIC applicants or parent/guardians applying on behalf of a child, shall provide documented proof of gross income received by each member of the household within the last 30 days. Applicants must have income at or below 185% of the federal poverty income guidelines. Applicants must be seen by a health professional such as a physician, nurse, or nutritionist who must determine whether the individual applicant is at nutrition risk. Details are outlined in Appendix A.10.

2.5 Policies & Procedures to Determine & Identify Ineligibility

WIC eligibility is determined at the initial certification appointment and the certification period is for a maximum of one year. Food benefits can only be issued up to three months in advance and at one time. WIC benefits are not automatically loaded to the EBT card. Benefits have a start and end date (one calendar month) and unused benefits expire and do not roll forward to the next month. Existing WIC

participants must reapply at the end of the certification period and if no longer eligible, they would not receive benefits. If participants do not reapply or fail to return to the clinic for the issuance of new benefits during the certification period, they are automatically converted to inactive/removed from the Program. Details are outlined in WIC Chapter 9: Determining Eligibility and Certification.

2.6 Policies & Procedures to Identify Work Search Requirements for Eligibility

There is no federal or state work or work search requirement for the WIC Program.

2.7 Barriers to Implementation of Program Integrity Measures

Barriers do not currently exist. Program integrity measures are incorporated throughout the CFR that governs the WIC Program and in Louisiana WIC Policies and Procedures for clinic, participant, and vendor management operations, including participant eligibility and enrollment, cost containment, benefit issuance and redemption, fraud and investigations, and participant and vendor violations.

2.8 Metrics & Data Points Measuring Success of Program Integrity & Fraud

Louisiana WIC Program success is measured by program enrollment, participation by category, retention of infant participants beyond one year of age, completion of required federal cost containment, and vendor management procedures. This includes routine monitoring and compliance investigations, monitoring of participant eligibility and enrollment via clinic self-management evaluations and state agency-conducted management evaluations.

In State Fiscal Year 2022 (SFY22), the Louisiana WIC State Agency received and resolved 279 complaints. In SFY22, 30 WIC client disputes were processed. Investigative findings revealed that 19 disputes were a result of vendor cashier errors, nine were a result of WIC participant errors, and one was due to WIC clinic error. One of these cases is currently pending resolution. There were zero civil rights complaints. In SFY22, there were 18 participant violations, including 10 disqualifications, seven warnings, and one demand to return a loaner breast pump. The disqualifications included accepting benefits while living out of the country, falsely reporting income, dual participation in Texas and Louisiana, threatening and providing physical harm to staff, receiving benefits for a foster child no longer in placement/care, and selling benefits online. The warnings included inappropriate behavior and communication toward WIC staff. These violations represent 0.02% of the WIC participant population for SFY22 (18 out of 84,549 participants). The Louisiana WIC State Agency conducted 19 management evaluations of WIC clinics.

In SFY22, Louisiana WIC received and resolved 119 complaints against authorized WIC vendors (grocery stores). The Louisiana WIC State Agency determined 20 of these complaints were valid and staff performed additional follow-up and notice to those vendors. The Louisiana WIC State Agency sanctioned (terminated, disqualified, or issued a civil money penalty in lieu of disqualification) 11 vendors for failing to comply with Louisiana WIC Vendor Rules and Regulations in SFY22. Louisiana WIC is required to conduct routine monitoring reviews and compliance investigations (inventory audits or compliance buys) on 5% of vendors annually. Louisiana WIC completed all routine monitoring reviews and compliance investigations.

2.9 Application Metrics Based on Procedural Reasons

Louisiana WIC applications are handled at the clinic level. Applicants are screened for eligibility (category, residency, income) when calling to make a WIC appointment and the application/certification is completed in the WIC management information system (MIS), also called Louisiana WIC Information Network (LAWIN), at the appointment. See the table below outlining the number of applications

entered into LAWIN for 2021, after being screened for eligibility, and the number of applicants denied due to not being at nutrition risk, categorically eligible, or meeting income eligibility. WIC does not have caseworkers or caseloads assigned to caseworkers.

Month-Year	Total Applicants	Total Applicants Denied
1/2021	4,937	498
2/2021	4,133	511
3/2021	5,172	532
4/2021	4,285	378
5/2021	4,057	450
6/2021	5,144	557
7/2021	4,802	507
8/2021	4,694	529
9/2021	4,562	536
10/2021	4,808	561
11/2021	4,650	555
12/2021	4,303	542
TOTAL	**55,547**	**6,156**

2.10 Administrative Appeals Process

Individuals are notified of their right to appeal eligibility decisions at certification and recertification by reading and signing the Rights and Responsibilities document. Applicants/participants are provided a copy of the Rights and Responsibilities document to retain for their records. Initially denied applicants are provided an ineligibility letter, which includes notification of their right to appeal. Disqualified or terminated participants are notified of their right to appeal the disqualification/termination letter. Participants who receive a disqualification letter/termination are informed of the following:

- Procedure for requesting a fair hearing including time limits.
- Right to have any position or argument on behalf of the applicant/ participant presented personally, or by a representative (such as a relative, friend, legal counsel, or spokesperson) in any Division of Administrative Law hearing.

Details are outlined in Appendix A.9. The Louisiana WIC State Agency did not have any fair hearing requests for ineligibility or civil rights in 2021.

Appendix A

1. Call Center Metrics
2. Electronic Medicaid Eligibility Verification System (eMEVS) User Manual
3. eMEVS Policy Information Form
4. Encounters Unit Desk Procedures V.1
5. Louisiana Verification Plan
6. Program Integrity: Current Policy Practices Descriptions
7. Women, Infants, and Children (WIC) Policy Information Form
8. Women, Infants, and Children (WIC) Policy & Procedure Manual - Chapter 3.6
9. Women, Infants, and Children (WIC) Policy & Procedure Manual - Chapter 5
10. Women, Infants, and Children (WIC) Policy & Procedure Manual - Chapter 9
11. Women, Infants, and Children (WIC) Policy & Procedure Manual - Chapter 11
12. Women, Infants, and Children (WIC) Policy & Procedure Manual - Chapter 22
13. Women, Infants, and Children (WIC) Vendor Policy - Chapter 7.08
14. Women, Infants, and Children (WIC) Vendor Policy - Chapter 7.09
15. Women, Infants, and Children (WIC) Vendor Policy - Chapter 7.14
16. Women, Infants, and Children (WIC) Vendor Policy - Chapter 7.16
17. Women, Infants, and Children (WIC) Vendor Policy - Chapter 7.17
18. Women, Infants, and Children (WIC) Vendor Policy - Chapter 7.18
19. Women, Infants, and Children (WIC) Vendor Transaction Procedures

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